FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028076

Facility Name: WATERFRONT TERRACE

Address: 7750 S. SHORE DR. (Number) CHICAGO (City) 60645 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-3230699

Date of Initial License for Current Owners: 04/01/83

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,372	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,816	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	510	23	4,381	4,914	8
9	SNF/PED					9
10	ICF	33,531	1,372	169	35,072	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,041	1,395	4,550	39,986	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.59%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/83

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/83 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 4,381

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	176,605	23,131	7,856	207,592		207,592		207,592			1
2	Food Purchase		168,381		168,381	(25,913)	142,468	(2,044)	140,424			2
3	Housekeeping	80,299	45,399		125,698		125,698		125,698			3
4	Laundry	50,031	13,266	3,975	67,272		67,272		67,272			4
5	Heat and Other Utilities			68,578	68,578		68,578	903	69,481			5
6	Maintenance	70,089	30,970	8,803	109,862		109,862	8,695	118,557			6
7	Other (specify):*			12,552	12,552		12,552	577	13,129			7
8	**TOTAL General Services**	377,024	281,147	101,764	759,935	(25,913)	734,022	8,131	742,153			8
	B. Health Care and Programs											
9	Medical Director			8,500	8,500		8,500		8,500			9
10	Nursing and Medical Records	1,289,266	74,212	3,724	1,367,202		1,367,202	(4,126)	1,363,076			10
10a	Therapy	12,445		17,148	29,593		29,593		29,593			10a
11	Activities	115,800	11,030	1,109	127,939		127,939		127,939			11
12	Social Services			2,001	2,001		2,001		2,001			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,417,511	85,242	32,482	1,535,235		1,535,235	(4,126)	1,531,109			16
	C. General Administration											
17	Administrative	106,651		228,000	334,651		334,651	(111,503)	223,148			17
18	Directors Fees											18
19	Professional Services			45,534	45,534		45,534	3,285	48,819			19
20	Dues, Fees, Subscriptions & Promotions			70,621	70,621		70,621	(43,950)	26,671			20
21	Clerical & General Office Expenses	118,716	19,226	193,384	331,326		331,326	(189,204)	142,122			21
22	Employee Benefits & Payroll Taxes			466,197	466,197	25,913	492,110		492,110			22
23	Inservice Training & Education			2,599	2,599		2,599		2,599			23
24	Travel and Seminar							525	525			24
25	Other Admin. Staff Transportation			11,500	11,500		11,500		11,500			25
26	Insurance-Prop.Liab.Malpractice			87,606	87,606		87,606	1,639	89,245			26
27	Other (specify):*			15,320	15,320		15,320	11,300	26,620			27
28	**TOTAL General Administration**	225,367	19,226	1,120,761	1,365,354	25,913	1,391,267	(327,908)	1,063,359			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,019,902	385,615	1,255,007	3,660,524		3,660,524	(323,903)	3,336,621			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: WATERFRONT TERRACE **#0028076** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,680	
	REPAIRS & MAINTENANCE		176	
			0	7,856
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,975	
			0	3,975
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		51,041	
	ELECTRICITY		9,149	
	WATER		8,388	
	CABLE TV - LOBBY		0	
			0	68,578
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,491	
	PAINTING & DECORATING		794	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		1,161	
	ELEVATOR MAINTENANCE & REPAIR		1,992	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,365	
	FIRE SERVICE		0	
			0	
			0	
			0	8,803
7	**OTHER**			
	SCAVENGER		12,552	
	SECURITY SERVICE		0	12,552
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,500	8,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	3,724	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	3,724
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	10,169	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	4,451	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	2,528	17,148
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,109	
			0	1,109
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,001	
			0	2,001
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WATERFRONT TERRACE **#0028076** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	228,000	228,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	4,748	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	38,340	
	COLLECTION FEES		2,446	45,534
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	40,771	
	EMPLOYEE WANT ADS	XIX F	16,060	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	5,642	
	LICENSES & PERMITS	XIX F	2,982	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,690	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,476	70,621
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,807	
	EQUIPMENT REPAIR & MAINTENANCE		13,753	
	OUTSIDE CLERICAL SERVICES		158,500	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,324	
	MESSENGER SERVICE		0	
			0	193,384

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	157,602	
	UNEMPLOYMENT COMPENSATION	XIX D	52,413	
	WORKERS COMPENSATION INSURANCI	XIX D	55,084	
	HOSPITALIZATION INSURANCE	XIX D	178,586	
	EMPLOYEE BENEFITS - OTHER	XIX D	17,670	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	4,842	466,197
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,599	2,599
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		11,500	11,500
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		87,606	87,606
27	**OTHER**			
	BAD DEBTS	VI 24	15,320	
				15,320

GRAND TOTAL COLUMN 3 OTHER 1,255,007

WATERFRONT TERRACE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	168,381
LESS SALES TAX	(643)
NET FOOD	167,738
TOTAL PATIENT CENSUS	39,986
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	119958
ADD # EMPLOYEE MEALS/DAY	60
TIME # DAYS	366
TOTAL EMPLOYEE MEALS	21960

PATIENT MEALS	119958
ADD EMPLOYEE MEALS	21960
TOTAL MEALS/YEAR	141918
NET FOOD	167738
DIVIDE TOTAL MEALS/YEAR	141918
COST PER MEAL	1.18
TIME EMPLOYEE MEALS	21960
EMPLOYEE MEAL RECLASSIFICATION	25913

Facility Name & ID Number WATERFRONT TERRACE #0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			99,213	99,213		99,213	33,535	132,748			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,439	23,439		23,439	143,581	167,020			32
33	Real Estate Taxes			137,158	137,158		137,158	3,201	140,359			33
34	Rent-Facility & Grounds			461,201	461,201		461,201	(461,201)				34
35	Rent-Equipment & Vehicles			8,936	8,936		8,936	6,659	15,595			35
36	Other (specify):*											36
37	**TOTAL Ownership**			729,947	729,947		729,947	(274,225)	455,722			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96,883	92,373	189,256		189,256	(3,416)	185,840			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,782	64,782		64,782		64,782			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		96,883	157,155	254,038		254,038	(3,416)	250,622			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,019,902	482,498	2,142,109	4,644,509		4,644,509	(601,544)	4,042,965			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	24,117	30		9
10	Interest and Other Investment Income	(12,048)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,401)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(643)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(3,690)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,452)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,320)	27		24
25	Fund Raising, Advertising and Promotional	(40,771)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(75,186)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (127,394)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(474,150)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (474,150)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (601,544)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WATERFRONT TERRACE

ID# 0028076

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	MARKETING SALARIES	(75,186)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(75,186)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,044)	0	0	0	0	0	0	0	0	0	0	(2,044)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	903	0	0	0	0	0	0	0	0	903	5
6	Maintenance	0	0	1,839	6,856	0	0	0	0	0	0	0	8,695	6
7	Other (specify):*	0	0	0	0	577	0	0	0	0	0	0	577	7
8	**TOTAL General Services**	(2,044)	0	2,742	6,856	577	0	0	0	0	0	0	8,131	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(4,126)	0	0	0	0	0	(4,126)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(4,126)	0	0	0	0	0	(4,126)	16
	C. General Administration													
17	Administrative	0	(228,000)	0	116,497	0	0	0	0	0	0	0	(111,503)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,452)	3,921	1,816	0	0	0	0	0	0	0	0	3,285	19
20	Fees, Subscriptions & Promotions	(44,461)	0	511	0	0	0	0	0	0	0	0	(43,950)	20
21	Clerical & General Office Expenses	(75,186)	(158,500)	37,873	6,609	0	0	0	0	0	0	0	(189,204)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	525	0	0	0	0	0	0	0	0	525	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,639	0	0	0	0	0	0	0	0	1,639	26
27	Other (specify):*	(15,320)	0	6,718	0	19,902	0	0	0	0	0	0	11,300	27
28	**TOTAL General Administration**	(137,419)	(382,579)	49,082	123,106	19,902	0	0	0	0	0	0	(327,908)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(139,463)	(382,579)	51,824	129,962	20,479	(4,126)	0	0	0	0	0	(323,903)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE # 0028076 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	24,117	6,425	2,993	0	0	0	0	0	0	0	0	33,535	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,048)	153,045	2,584	0	0	0	0	0	0	0	0	143,581	32
33	Real Estate Taxes	0	0	3,201	0	0	0	0	0	0	0	0	3,201	33
34	Rent-Facility & Grounds	0	(461,201)	0	0	0	0	0	0	0	0	0	(461,201)	34
35	Rent-Equipment & Vehicles	0	0	6,659	0	0	0	0	0	0	0	0	6,659	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	12,069	(301,731)	15,437	0	0	0	0	0	0	0	0	(274,225)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(3,416)	0	0	0	0	0	(3,416)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(3,416)	0	0	0	0	0	(3,416)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(127,394)	(684,310)	67,261	129,962	20,479	(7,542)	0	0	0	0	0	(601,544)	45

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 228,000	DYNAMIC HEALTHCARE CONSULTANT	100.00%	$	$ (228,000)	1
2	V	21	BOOKKEEPING SERVICES	158,500	" "			(158,500)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	461,201	WATERFRONT TERRACE ASSOCIATES	100.00%		(461,201)	7
8	V	30	DEPRECIATION		" "		6,425	6,425	8
9	V	19	ACCOUNTING & LEGAL		" "		3,921	3,921	9
10	V	32	INTEREST		" "		153,045	153,045	10
11	V								11
12	V								12
13	V								13
14	Total			$ 847,701			$ 163,391	$ * (684,310)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANT	100.00%	$ 903	$ 903	15
16	V	6	REPAIR & MAINT.		" "	100.00%	1,839	1,839	16
17	V	19	PROFESSIONAL FEES		" "	100.00%	1,816	1,816	17
18	V	20	DUES AND SUBSCRIPTION		" "	100.00%	511	511	18
19	V	21	CLERICAL & GENERAL		" "	100.00%	37,873	37,873	19
20	V	24	SEMINARS AND TRAVEL		" "	100.00%	525	525	20
21	V	26	INSURANCE		" "	100.00%	1,639	1,639	21
22	V	27	EMP. BEN.- GEN, ADMIN.		" "	100.00%	6,718	6,718	22
23	V	30	DEPRECIATION		" "	100.00%	2,993	2,993	23
24	V	32	INTEREST		" "	100.00%	2,584	2,584	24
25	V	33	REAL ESTATE TAXES		" "	100.00%	3,201	3,201	25
26	V	35	EQUIPMENT RENTAL		" "	100.00%	6,659	6,659	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 67,261	$ * 67,261	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP.- D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 6,856	$ 6,856	15
16	V	17	ADMIN CMP.- M. MAUER		" "	100.00%	16,065	16,065	16
17	V	17	ADMIN CMP.- M. AARON		" "	100.00%	17,812	17,812	17
18	V	17	ADMIN CMP.- F. AARON		" "	100.00%	20,272	20,272	18
19	V	17	ADMIN CMP.- S. GOLDSTEIN		" "	100.00%			19
20	V	17	ADMIN CMP.- S. KOPLIN		" "	100.00%	10,313	10,313	20
21	V	17	ADMIN CMP.- D. MAGAFAS		" "	100.00%	8,413	8,413	21
22	V	17	ADMIN CMP.- S. LEVY		" "	100.00%	14,409	14,409	22
23	V	17	ADMIN CMP.- HOWARD ALTER		" "	100.00%	12,000	12,000	23
24	V	17	ADMIN CMP.- NON-OWNER		" "	100.00%	17,213	17,213	24
25	V	21	CLERICAL. CMP. - S. AARON		" "	100.00%	6,609	6,609	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 129,962	$ * 129,962	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 577	$ 577	15
16	V	27	EMP. BEN. - M. MAUER		" "	100.00%	1,303	1,303	16
17	V	27	EMP. BEN. - M. AARON		" "	100.00%	1,968	1,968	17
18	V	27	EMP. BEN. - F. AARON		" "	100.00%	5,814	5,814	18
19	V	27	EMP. BEN. - S. GOLDSTEIN		" "	100.00%			19
20	V	27	EMP. BEN. - S. KOPLIN		" "	100.00%	3,067	3,067	20
21	V	27	EMP. BEN. - D. MAGAFAS		" "	100.00%	793	793	21
22	V	27	EMP. BEN. - S. LEVY		" "	100.00%	2,014	2,014	22
23	V	27	EMP. BEN. - H. ALTER		" "	100.00%	1,244	1,244	23
24	V	27	EMP. BEN. - NON-OWNER		" "	100.00%	2,561	2,561	24
25	V	27	EMP. BEN. - S. AARON		" "	100.00%	1,138	1,138	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 20,479	$ * 20,479	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$ 12,723	DYNAMIC HEALTHCARE CONSULTANTS		$ 12,723	$	15
16	V	19	PROFESSIONAL FEES	2,320	" "		2,320		16
17	V	22	EMPLOYEE BENEFITS	68	" "		68		17
18	V	39	ANCILLARY SERVICES	65,809	" "		65,809		18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	21,933	LINCOLN MEDICAL SUPPLIES, INC		17,807	(4,126)	21
22	V	39	ANCILLARY SERVICES	18,163	" "		14,747	(3,416)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 121,016			$ 113,474	$ * (7,542)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER		ADMINISTRATION			SCHEDULE ATTACHED		SALARY	$ 16,065	17-7	1
2	MAURICE AARON		ADMINISTRATION					SALARY	17,812	17-7	2
3	FRED AARON		ADMINISTRATION					SALARY	20,272	17-7	3
4	FRED AARON		ADMINISTRATION					SALARY	6,500	17-1	4
5	SHARON AARON		CLERICAL					SALARY	6,609	21-7	5
6	HOWARD ALTER		ADMINISTRATO	0.00	0	40		SALARY	95,851	17-1	6
7	HOWARD ALTER		ADMINISTRATO	0.00	0			SALARY	12,000	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 175,109		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	427,864	12	$ 9,658	$	39,986	$ 903	1
2	6	REPAIR & MAINT.	" "	427,864	12	19,683		39,986	1,839	2
3	19	PROFESSIONAL FEES	" "	427,864	12	19,431		39,986	1,816	3
4	20	DUES AND SUBSCRIPTION	" "	427,864	12	5,469		39,986	511	4
5	21	CLERICAL & GENERAL	" "	427,864	12	405,253	290,672	39,986	37,873	5
6	24	SEMINARS AND TRAVEL	" "	427,864	12	5,616		39,986	525	6
7	26	INSURANCE	" "	427,864	12	17,537		39,986	1,639	7
8	27	EMP. BEN.- GEN, ADMIN.	" "	427,864	12	71,885		39,986	6,718	8
9	30	DEPRECIATION	" "	427,864	12	32,025		39,986	2,993	9
10	32	INTEREST	" "	427,864	12	27,646		39,986	2,584	10
11	33	REAL ESTATE TAXES	" "	427,864	12	34,248		39,986	3,201	11
12	35	EQUIPMENT RENTAL	" "	427,864	12	71,259		39,986	6,659	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 719,710	$ 290,672		$ 67,261	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 65,436	$ 65,436	4	$ 6,856	1
2	17	ADMIN CMP.- M. MAUER	" "	40	11	170,000	170,000	4	16,065	2
3	17	ADMIN CMP.- M. AARON	" "	40	9	170,000	170,000	4	17,812	3
4	17	ADMIN CMP.- F. AARON	" "	47	6	119,100	119,100	8	20,272	4
5	17	ADMIN CMP.- S. GOLDSTEIN	" "	45	3	24,000	24,000			5
6	17	ADMIN CMP.- S. KOPLIN	" "	40	7	72,815	72,815	6	10,313	6
7	17	ADMIN CMP.- D. MAGAFAS	" "	45	9	80,395	80,395	5	8,413	7
8	17	ADMIN CMP.- S. LEVY	" "	45	11	152,350	152,350	4	14,409	8
9	17	ADMIN CMP.- HOWARD ALTER	" "	40	1	12,000	12,000	40	12,000	9
10	17	ADMIN CMP.- NON-OWNER	" "	45	9	164,490	164,490	5	17,213	10
11	21	CLERICAL. CMP. - S. AARON	" "	40	11	69,932	69,932	4	6,609	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,100,518	$ 1,100,518		$ 129,962	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 5,508	$	4	$ 577	1
2	27	EMP. BEN. - M. MAUER	" "	40	11	13,783		4	1,303	2
3	27	EMP. BEN. - M. AARON	" "	40	9	18,779		4	1,968	3
4	27	EMP. BEN. - F. AARON	" "	47	6	34,154		8	5,814	4
5	27	EMP. BEN. - S. GOLDSTEIN	" "	45	3	25,404				5
6	27	EMP. BEN. - S. KOPLIN	" "	40	7	21,655		6	3,067	6
7	27	EMP. BEN. - D. MAGAFAS	" "	45	9	7,575		5	793	7
8	27	EMP. BEN. - S. LEVY	" "	45	11	21,295		4	2,014	8
9	27	EMP. BEN. - H. ALTER	" "	40	1	1,244		40	1,244	9
10	27	EMP. BEN. - NON-OWNER	" "	45	9	24,475		5	2,561	10
11	27	EMP. BEN. - S. AARON	" "	40	11	12,038		4	1,138	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 185,910	$		$ 20,479	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION						12,723	2
3	19	PROFESSIONAL FEES	" "						2,320	3
4	22	EMPLOYEE BENEFITS	" "						68	4
5	39	ANCILLARY SERVICES	" "						65,809	5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						17,807	9
10	39	ANCILLARY SERVICES	" "						14,747	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 113,474	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BANK FINANCIAL		X	MORTGAGE	$36,603.24	10/99	$ 3,050,000	$ 1,809,059	10/09	7.7500	$ 153,045	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				571,070		5.7500	20,983	6
7			X	INSURANCE FINANCING							2,044	7
8	BANK FINANCIAL		X	VAN LOAN				3,569		7.0000	412	8
9	TOTAL Facility Related				$36,603.24		$ 3,050,000	$ 2,383,698			$ 176,484	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,050,000	$ 2,383,698			$ 176,484	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 83,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 107,158	2
3. Under or (over) accrual (line 2 minus line 1).		$ 24,158	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 113,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 137,158	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	82,615	8
2000	78,218	9
2001	80,252	10
2002	81,152	11
2003	107,158	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WATERFRONT TERRACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028076

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-412-045-0000	NURSING HOME	$ 106,431.35	$ 106,431.35
2.	21-30-412-038-0000	NURSING HOME	$ 726.16	$ 726.16
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 107,157.51	$ 107,157.51

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,824 B. General Construction Type: Exterior BRICK Frame STEEL & CONCRETI Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	37,824	1983	$ 100,000	1
2					2
3	TOTALS	37,824		$ 100,000	3

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1983		$ 1,508,000	$	35	$ 43,086	$ 43,086	$ 937,121	4
5											5
6											6
7											7
8					41,457	1,063		1,184	121	13,424	8
	Improvement Type**										
9	ROOF			1983	21,787		10			21,787	9
10	LEASEHOLD IMPROVEMENT			1985	950		15			950	10
11	LEASEHOLD IMPROVEMENT			1986	3,800	160	10		(160)	3,800	11
12	LEASEHOLD IMPROVEMENT			1986	1,005	42	15		(42)	1,005	12
13	ROOF			1990	13,634	433	10		(433)	13,634	13
14	SUSPENDED CEILING			1990	20,776	660	15	660		18,633	14
15	LEASEHOLD IMPROVEMENT			1991	7,956	253	10		(253)	7,956	15
16	LEASEHOLD IMPROVEMENT			1991	1,491	47	15	47		1,203	16
17	LEASEHOLD IMPROVEMENT			1992	18,033	572	10		(572)	18,033	17
18	LEASEHOLD IMPROVEMENT			1992	1,097	35	15	35		837	18
19	LEASEHOLD IMPROVEMENT			1993	7,742	246	31.5	246		2,880	19
20	LEASEHOLD IMPROVEMENT			1993	3,426	88	39	88		1,008	20
21	LEASEHOLD IMPROVEMENT			1994	25,007	642	39	642		6,713	21
22	ELEVATOR REPAIR			1995	1,500	38	39	38		377	22
23	SPRINKLER REPAIR			1995	4,154	107	39	107		1,047	23
24	BOILER REPAIR, WATER PUMP, ALARM			1996	6,033	154	39	154		1,342	24
25	FENCING			1996	756	50	15	50		425	25
26	NURSE STATION			1996	5,300	136	39	136		1,105	26
27	HANDRAILS			1996	3,735	96	39	96		772	27
28	PARKING LOT REPAVING			1997	14,968	998	15	998		6,582	28
29	TUCKPOINTING, ROOF REPAIR			1997	25,814	662	39	662		4,882	29
30	DRAPERY			1997	14,754	378	39	378		2,780	30
31	DOORS & SIGNS			1997	8,428	216	39	216		1,593	31
32	AIR HANDLER REPAIR & PUMPS			1997	17,005	436	39	436		3,216	32
33	REMODELING			1997	59,133	1,517	39	1,517		11,346	33
34	NURSE STATION			1997	5,106	131	39	131		966	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FLOOR TILES, HANDRAILS, BUMPERGUARDS	1998	$ 44,786	$ 1,148	39	$ 1,148	$	$ 7,404	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNET	1998	6,419	165	39	165		1,068	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		605	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		1,324	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		328	41
42	REMODELING	1998	21,934	562	39	562		3,606	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		2,203	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		635	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	538	39	538		3,462	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		2,851	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	259	39	259		1,660	47
48	FIRE ALARM	1999	10,286	264	39	264		1,504	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		5,160	49
50	BOILER WORK	1999	7,345	188	39	188		1,069	50
51	CABLE WORK	1999	433	11	39	11		64	51
52	CARPET	1999	18,828	483	39	483		2,701	52
53	ELEVATOR WORK	1999	2,017	52	39	52		295	53
54	AIR CONDITIONING	1999	7,350	189	39	189		1,096	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		1,279	55
56	ROOF WORK	1999	2,187	56	39	56		310	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,525	39	1,525		8,157	57
58	WINDOWS	1999	5,513	141	39	141		791	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	833	39	833		4,545	59
60	RELATED PARTY - NURSE STATION	1999	19,656	504	39	504		2,751	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		24,697	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		3,080	62
63	NURSE CALL SYSTEM	2000	2,778	102	27.5	102		460	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		1,695	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		536	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	372	27.5	372		1,715	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		13,280	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		442	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		434	69
70	TOTAL (lines 4 thru 69)		$ 2,506,825	$ 27,585		$ 69,332	$ 41,747	$ 1,186,624	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,506,825	$ 27,585		$ 69,332	$ 41,747	$ 1,186,624	1
2	EXHAUST FAN	2000	890	32	27.5	32		153	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		187	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		524	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247	1,607	7	1,607		8,576	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		1,023	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		827	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		758	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		821	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		325	10
11	AC UNIT	2001	786	28	27.5	28		100	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	276	27.5	276		690	12
13	ELEVATOR REPAIR	2002	6,244	135	27.5	135		315	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		131	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		211	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		103	16
17	GENERATOR REPAIRS	2003	71,609	2,604	27.5	2,604		3,797	17
18	DECK & FENCE	2004	10,197	340	15	340		340	18
19	A/C REPAIR	2004	2,200	36	27.5	36		36	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	75	27.5	75		75	20
21	WATER HEATER	2004	6,937	116	27.5	116		116	21
22	NURSE CALL STATION	2004	585	10	27.5	10		10	22
23	GENERATOR REPAIRS	2004	1,250	21	27.5	21		21	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,668,777	$ 34,337		$ 76,084	$ 41,747	$ 1,205,763	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 540,540	$ 43,952	$ 49,482	$ 5,530	10	$ 286,432	71
72	Current Year Purchases	42,576	25,546	2,129	(23,417)	10	2,129	72
73	Fully Depreciated Assets	310,133					310,133	73
74	RELATED PARTY	26,303	1,329	1,963	634		19,297	74
75	TOTALS	$ 919,552	$ 70,827	$ 53,574	$ (17,253)		$ 617,991	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RELATED PARTY			$ 5,261	$ 601	$ 105	$ (496)		$ 5,261	76
77		USED VEHICLE	2002	14,925	2,866	2,985	119	5	5,970	77
78										78
79										79
80	TOTALS			$ 20,186	$ 3,467	$ 3,090	$ (377)		$ 11,231	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,708,515	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 108,631	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,748	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 24,117	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,834,985	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 6,227 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		2001 HONDA	$ 429.00	$ 5,148	17
18			FRINGE BENEFIT	(2,439)	18
19					19
20					20
21	TOTAL		$ 429.00	$ 2,709	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 38,217	$		$ 38,217	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,663			1,663	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			52,493			52,493	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				64,896		64,896	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, LAB, RADIOLOGY Other (specify):	39-2					31,987		31,987	13
14	TOTAL			$		$ 92,373	$ 96,883		$ 189,256	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	804,013		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,313		6
7	Other Prepaid Expenses	5,584		7
8	Accounts Receivable (owners or related parties)	307,564		8
9	Other(specify): RE TAX ESCROW	12,799		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,164,273	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	868,755		15
16	Equipment, at Historical Cost	908,172		16
17	Accumulated Depreciation (book methods)	(1,009,142)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 767,785	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,932,058	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 324,368	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	574,639		29
30	Accrued Salaries Payable	151,843		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,365		31
32	Accrued Real Estate Taxes(Sch.IX-B)	113,000		32
33	Accrued Interest Payable	2,658		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,184,873	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,184,873	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 747,185	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,932,058	$	48

*(See instructions.)

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 741,924	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	(3,043)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 738,881	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	136,304	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(128,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 8,304	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 747,185	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,723,567	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,723,567	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	43,797	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 43,797	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,048	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,048	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS EARNED	1,401	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,401	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,780,813	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	759,935	31
32	Health Care	1,535,235	32
33	General Administration	1,365,354	33
	B. Capital Expense		
34	Ownership	729,947	34
	C. Ancillary Expense		
35	Special Cost Centers	189,256	35
36	Provider Participation Fee	64,782	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,644,509	40
41	**Income before Income Taxes (line 30 minus line 40)****	136,304	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 136,304	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,888	1,989	$ 61,958	$ 31.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,448	3,567	77,554	21.74	3
4	Licensed Practical Nurses	28,438	31,084	610,894	19.65	4
5	Nurse Aides & Orderlies	54,082	56,496	472,695	8.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	553	641	12,445	19.41	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,844	2,018	26,741	13.25	9
10	Activity Assistants	9,870	10,169	89,059	8.76	10
11	Social Service Workers					11
12	Dietician	1,667	1,777	25,135	14.14	12
13	Food Service Supervisor					13
14	Head Cook	5,926	6,194	57,612	9.30	14
15	Cook Helpers/Assistants	10,140	10,441	93,858	8.99	15
16	Dishwashers					16
17	Maintenance Workers	4,616	4,929	70,089	14.22	17
18	Housekeepers	10,657	11,148	80,299	7.20	18
19	Laundry	5,835	6,071	50,031	8.24	19
20	Administrator	1,977	2,035	106,651	52.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,692	6,015	118,716	19.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,089	2,180	23,703	10.87	31
32	Other Health C: CARE PLN CRDN	2,141	2,326	42,462	18.26	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,863	159,080	$ 2,019,902 *	$ 12.70	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 7,680	1-3	35
36	Medical Director		8,500	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		3,724	10-3	39
40	Physical Therapy Consultant		10,169	10a-3	40
41	Occupational Therapy Consultant		4,451	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		2,528	10a-3	43
44	Activity Consultant		1,109	11-3	44
45	Social Service Consultant		2,001	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 40,162		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HOWARD ALTER	ADMIN		$ 95,851
DIANA MAGAFAS	ADMIN		10,800
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,651

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 228,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 228,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		45,534
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 45,534

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 55,084
Unemployment Compensation Insurance		52,413
FICA Taxes		157,602
Employee Health Insurance		178,586
Employee Meals		25,913
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		17,670
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		4,842
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 492,110

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,272
Advertising: Employee Recruitment	16,060
Health Care Worker Background Check	1,476
(Indicate # of checks performed 83)	
MARKETING/ADV/PROMO	40,771
TRUST/FRANCHISE/CONTRIB/ETC	3,690
LICENSES & PERMITS	1,710
DUES & SUBSCRIPTIONS	5,642
MGMT CO ALLOCATION	511
TRUST/FRANCHISE/CONTRIB/ETC	(3,690)
Less: Public Relations Expense	(0)
Non-allowable advertising	(40,771)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,671

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
MGMT CO ALLOCATION	525
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 525

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$ 0	$	$	$	$	$

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL OF LONG TERM CARE $5642**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,209** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **64,782**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **25,913** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees